JACKSON COUNTY School District

"Raising the Standard"

Seizure Action Plan

To be completed by parents, health care teams and reviewed with necessary school staff. Original will be placed in health folder. If authorized by parent, copies will be given to each teacher and administrator.

Emergency Care Plan for: _____ Date of Birth: _____
Parent/ Guardian: _____ Address: _____
Home phone:_____ Work phone: _____ Cell/Pager: _____
Parent/ Guardian: _____ Address:_____
Home phone:_____ Work phone: _____ Cell/Pager: _____
Other Emergency Contact:_____ Relationship:_____
Home phone:_____ Work phone: _____ Cell/Pager: _____
Doctor/ Health Care Provider:_____ Telephone: _____

How often do seizures occur?_____
_____
What is the usual time of day?_____
_____
Are there things that "trigger" or "bring on" a seizure?_____
_____
Are there any warning signs?_____
_____
Please describe what the seizures look like (what part of the body is affected): _____
_____
How long does it usually last?_____
_____
Child/ teen's behavior after a seizure: _____
_____

MEDICATION INFORMATION

NAME	DOSE	TIME	DIRECTIONS

If your child is taking medications at school, please complete the "Medical Consent Form".

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<u>EMERGENCY PROCEDURE</u> which will be followed unless you inform JCSD in writing and provide an alternate Health Care Plan:

1. During a seizure, staff will protect the student from injury by moving objects out of the way and placing a towel, jacket or hands under the head.
2. After the seizure has ended, staff will roll the student onto his/her side to prevent aspiration of vomit or liquid in the mouth.
3. After the seizure has ended, we will call a parent/ guardian or other emergency contact.
4. (Parent/guardian's additional recommendation) _____
_____
5. If a seizure lasts more than 5 minutes or if one seizure follows another in a 10-minute period, we will call 911 and a parent/ guardian or other emergency contact.
6. If the student is not breathing or is having difficulty breathing, we will begin rescue breathing and call 911.
7. We will always call 911 if student appears seriously ill, seriously injured, or we are concerned about the student's immediate health and safety.

I have reviewed the above information.

This information may be shared with <u>appropriate</u> staff members and emergency personnel.

Parent/Guardian signature _____ **Date** _____

Healthcare Provider signature _____ **Date** _____

School Nurse signature_____ **Date** _____

Update Signatures: Parent _____ ***Date*** _____

Healthcare Provider _____ ***Date*** _____

School Nurse _____ ***Date*** _____

This form should be completed by your physician, signed by the physician and the parent/guardian, and submitted with other registration forms and proof of residency at the appropriate school during Jackson County School District registration or as soon as possible.

The signed form may be mailed or faxed to your child's school. Please contact the school for address or fax number.